

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 1250

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Inquest into the Death of: SCARLET RYLE SPAIN

Delivered On: 18 April 2013

Delivered At: Coroners Court of Victoria
Level 11, 222 Exhibition Street
Melbourne

Hearing Dates: 21 March 2013

Findings of: CORONER K. M. W. PARKINSON

Police Coronial Support Unit Leading Senior Constable Nadine Harrison appeared to assist the Coroner

I, K. M. W. PARKINSON, Coroner having investigated the death of SCARLET RYLE SPAIN and having held an inquest in relation to this death on 21 March 2013 – 22 March 2013 at Coroners Court of Victoria, Level 11, 222 Exhibition Street Melbourne 3000 find that the identity of the deceased was SCARLET RYLE SPAIN born on 14 April 1991, aged 20 and the death occurred on 5 April 2012 at Royal Melbourne Hospital, Grattan Street, Parkville 3050

from:

1a. HEAD INJURIES SUSTAINED FROM FALL FROM A HEIGHT

in the following circumstances:

1. Ms Scarlet Spain was born on 14 April 1991, and she was 20 years of age. Scarlet was an intelligent, happy and musically talented young woman and a much loved daughter and sister.
2. On Friday 30 March 2012, Scarlet attended a party being held in an abandoned warehouse/ business premises at 455 Lygon Street, Brunswick East, where a number of people had taken occupancy as squatters. Two of these occupants, Ms Leah Senior and Mr Alexander Parke gave evidence in the proceedings.
3. The party was organised by the residents of the warehouse and approximately 50 people attended. Scarlet is reported to have arrived at the party at approximately 8pm. She was reported to have consumed very little alcohol and was not substance affected. Mr Alexander Parke, another occupant of the premises, stated that she appeared very 'social' and at no point did she appear to be depressed or emotionally distressed.
4. The premises comprised a ground floor level, which opened as a former shop front to Lygon Street and to a laneway at the rear. The property was accessed by the rear gates and entry way. The property also had a mezzanine level accessed by a wooden stairway. The property was clearly derelict and in an unsafe condition for business occupancy and certainly unsafe for residential occupancy. There was no power supply to the premises and limited water supply.

5. The owner of the building, Mr Levent Aydodu gave evidence that he had not authorised the occupancy of the premises and was unaware of the squatters until after Scarlet's death when a friend brought the tragedy to his attention. The building owner had secured the building by padlock, which had been removed, and access gained through the rear laneway access door. The front of Lygon Street facing shopfront was locked and well secured. Mr Aydodu stated that he was not the owner, occupier or developer of the next door property and it was not associated with his business in any way.
6. The residents arranged for a regular power supply by hooking into the supply of neighbouring properties. They regularly connected a power lead to the factory premises next door. The evidence of Ms Senior is that this was with consent of the owner of that property, whom she also believed incorrectly, was the owner of the property, which she was occupying.
7. The party was organised as a vacating party, after Ms Senior became aware that the property was to be demolished for construction of apartments. She was advised of this by the owner or occupier of the next door warehouse. She was also told that she could no longer receive power from the property next door. The party was supplied with power for the evening by an extension lead from the property, which bounded the laneway at the rear. This property was owned by Mr James Merrett and he also attended the party.
8. During the course of the evening partygoers had been climbing onto the roof of the property, and making use of the roof area, including climbing up to the roof of the next door property to enable a better view of the Lygon Street activity.
9. Partygoers were coming and going from the rooftop, climbing up internal wooden stairs to the mezzanine and then making their way out of a louvered window from which the louvers had been removed, onto the roof.

10. Mr Parke stated:

"There were a lot of people there on the night and many people were moving between different areas of the building. I noticed numerous people even going upstairs into the mezzanine level and many others even gaining access to the roof. A lot of us enjoyed going up there regularly. We were of the opinion that the roof was quite structurally sound except

for one part of the roof near the window, which we went through in order to get up there. We were even telling people about that part of the roof, not thinking of the dangers involved with the sky light.

11. Police report that the floor at the window area was comprised of fibreboard, which as a result, of weather had deteriorated and lost its integrity. Police regarded the roof access as dangerous due to integrity issues and also due to lack of lighting and did not attempt to access it that evening.
12. At approximately 1.20am, a guest at the party, Mr Nathan Gardner and Scarlet went up onto the roof. Mr Gardner stated that they wanted to see “what was happening up there and to look at the street below”.
13. Mr Gardner’s evidence was that Scarlet followed him onto the roof and he offered to assist her to climb up onto the next roof, a climb or jump of about 1 metre.
14. He states that he was conscious that Scarlet was directly behind him as he made his way around the perimeter of the roof. He chose the perimeter to walk, as he believed that would be the safest access route and where bearers were more likely to have been placed. He did not discuss any issues of safety with Scarlet either before she entered the roof area or during their progress.
15. He stated that they started to climb up towards the upper level of the building and tried to climb the wall, which was above the mezzanine level of the building, this would have gotten us to the highest point of the warehouse. I was walking in front of Scarlet, we were not really chatting but I asked her a question: “Do you need any help up?” She said: “No, no, no”.
16. Approximately 2 metres from the edge of the roof (and Mr Gardner’s pathway) there was a skylight comprised of polymer plastic. The skylight sat above a vault in the ceiling leading directly to the floor in the main warehouse area on the ground floor below. The distance between the skylight on the roof and the floor below was approximately 5.4 metres. The floor below was a concrete surface.

17. Mr Gardner states that shortly afterwards he was conscious that Scarlet was not behind him and almost at that time he heard screaming from inside the premises. He made his way down to the ground level where he saw Scarlet lying on the floor. His evidence is that he did not see or hear her fall from the rooftop and he was not aware that Scarlet was anywhere near the skylight.
18. The evidence is that at approximately 1.30am Scarlet fell through the skylight and fell 5.4 metres to the concrete floor below. There was nothing to break Scarlet's fall to the floor below.
19. Ambulance paramedics were in attendance when police arrived at 1.50am and Scarlet was stabilised and transported to the Royal Melbourne Hospital.
20. Scarlet sustained catastrophic brain injury and despite intensive neurosurgical and intensive care efforts, her prospects for any meaningful recovery were poor. Mechanical life support measures were ceased and Scarlet died on 5 April 2012.
21. An autopsy was performed by Forensic Pathologist, Dr Mathew Lynch. Dr Lynch stated that a reasonable medical cause of death was: 1(a) Head injuries sustained in a fall from a height.
22. Toxicology analysis of ante-mortem samples was negative for common drugs or alcohol.

The Building environment

23. The roof structure was apparently in a state of poor repair. The inside of the building was generally in a derelict state and not fit for occupancy.
24. There was no lighting up on the roof area and it is likely that the skylight was not readily apparent, particularly to someone who had not been on the roof in daylight or at all previously, as was the case with Scarlet.
25. The building was derelict, the roof, the skylight and access to the roof in poor repair. The skylight was not designed to bear weight and likely to fail in the event that any weight was placed on the Perspex polymer plastic covering.

26. Whilst it is possible that Scarlet used the skylight deliberately as a seat, or to stand on it to get a better view, it is more likely that Scarlet stepped onto the skylight, likely unaware of its presence, when she was making her way across the mezzanine roof in order to access the roof of the next door premises.

27. I am satisfied that there were no suspicious circumstances and that Scarlet's tragic death was accidental.

28. I find that Ms Scarlet Ryle Spain died on 5 April 2012 and that her death was as a result of head injuries sustained in a fall from a height.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. I understand that the partygoers and in particular the organisers are deeply affected by the death of Scarlet, however it appears that they still have little appreciation of the risks of such premises and it is for that reason that I make the following comments.
2. Whilst it is unclear how Scarlet came to be in proximity to the skylight or how it was that she came to fall through it, as I have earlier stated I am satisfied that it is likely she did not see it and accidentally stepped on the opaque Perspex plastic skylight.
3. It is clear that the premises were unsafe for general access and occupancy for any purpose. It appears that there was a lack of understanding that a roof can be unsafe to access at any time, and particularly at night with no lighting, no safety restraints and when the roof is in a state of poor repair.
4. Whilst it might seem to the uninformed, that residential occupancy and/or party use of such premises is harmless and that they are an unusual and interesting venue for party use, it cannot be emphasised strongly enough that these premises are derelict and vacant for a reason.

5. That is, they are not safe for ill prepared access or for occupancy. The risks in such a building include not only the danger arising from lack of or deteriorating structural integrity and lighting to which Scarlet was exposed, but also other risks such as fire. A significant risk in this case where the lighting was provided by candlelight and there was limited and restricted exit availability.
6. It was of concern to hear from Ms Senior that she had assessed the building as safe from fire because it was a brick building. This evidence and that of Mr Gardner and Mr Parke indicates a lack of understanding or awareness of risk, which may well be replicated in the community of people who occupy such buildings.
7. In the circumstances, there is no evidence to suggest that either the property owner, or the local governing authorities or police could reasonably have been expected to have knowledge of the unlawful occupancy, or to have taken any action to ensure the premises were vacated. They usually become aware of occupancy due to either complaints as to noise, or possible criminal behaviour, neither of which factors applied to the occupants of the building in question.
8. Nor does the evidence suggest that the premises had not been appropriately secured against entry by the property owner, prior to entry being gained by the occupants.
9. It does not appear to me that there are any additional regulatory or inspectorial powers, which might usefully be recommended in order to avoid such a tragedy in the future.
10. The prevention of this type of incident happening again lies in creating an awareness and understanding of the risks associated with such buildings, amongst those most likely to seek occupancy or access to them. I note that a number of those present at the party and occupants of the building were students and perhaps this issue may be a matter that university housing officers and other housing bodies might publicise.
11. In those circumstances, this finding is directed to be forwarded to the Housing Officers for each of the universities; the Tenants Union of Victoria and the Federation of Community Legal Services for their information.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. In view of my comments above, I make no recommendations in this case.

I direct that a copy of this finding be provided to the following:

The family of Ms Scarlet Spain
The Interested Parties
The investigating Police Officer
University Housing Officers
Tenants Union of Victoria
Federation of Community Legal Services

Signature:



CORONER K. M. W. PARKINSON

Date: 18 April 2013

